

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8985

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08955

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 22yrs. 1mo. 10days		d. STREET ADDRESS 1009 W. 38th St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Anderson		4. DATE OF DEATH Month August Day 22 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 3, 1901
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Anderson		14. MOTHER'S MAIDEN NAME Addie Sakers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 350X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Parkinsonism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with post-encephalitis.			
INTERVAL BETWEEN ONSET AND DEATH Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 to August 22, 1960 , that (I) (we) last saw the deceased alive on August 22, 1960 , and that death occurred at 11:25 PM on the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 8/23/60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial		23b. DATE THEREOF 8-27-60	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		24b. REC'D BY REGISTRAR AUG 31 '60	
24c. ADDRESS Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Arthur G. Haight	

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8986

08956

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3337 N. Charles St., Balto. 18, Md.	
3. NAME OF DECEASED (Type or print) First Katherine Middle Butler Last Blanck		4. DATE OF DEATH Month August Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-89
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 01 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Butler		14. MOTHER'S MAIDEN NAME Anastasia Concoran	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Springfield Hospital Records, Sykesville, Md.	
17. INFORMANT Springfield Hospital Records, Sykesville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral hemorrhage due to hypertension. DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B. S. assoc. with cerebral arteriosclerosis with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH 10 days. Hypertension years.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1, 1960 to August 24, 1960 , that (I) (we) last saw the deceased alive on August 24, 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED August 24, 1960	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital, Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 27, 1960	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John A. Monan		25a. REC'D BY REGISTRAR AUG 29 '60	
ADDRESS 3000 E. Baltimore St.		25b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

05-20

FIELD NO. 3-20-20

8228

(14)



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be examined within 24 hours after death. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be examined within 24 hours after death. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 1

8981

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08957

Item 15 Film 271 9-16-60 et

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown c. LENGTH OF STAY IN 1b 15 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION West Baltimore St. (Ext.)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown d. STREET ADDRESS West Baltimore St. (Ext.) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Donald Last Boone		4. DATE OF DEATH Month August Day 9 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1906
9. AGE (In years lost birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53	11. IF UNDER 24 HRS. Months 53 Days 53 Hours 53 Min. 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Salesman		10b. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Boone		14. MOTHER'S MAIDEN NAME Carrie Wolfe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-14-8338	
17. INFORMANT Mrs. J. Donald Boone		Address Taneytown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage DUE TO Hypertension and Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 1 year DUE TO 1 year		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10/59 to 8/9 , 19 60 that (I) (we) last saw the deceased alive on 8/1 , 19 60 and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE R. S. McVaugh		22b. DATE SIGNED 8/10/60	
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		22d. ADDRESS Taneytown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 12, 1960	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Silver Run, Carroll, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss		25a. REC'D BY REGISTRAR DATE AUG 15 '60	
ADDRESS Taneytown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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STANDARD OF DIAL

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DEPUTY MEDICAL EXAMINER: The certificate should be executed within 24 hours after death. If an X-ray is necessary, please secure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8987

08958

1. PLACE OF DEATH a. COUNTY Carroll										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland										b. COUNTY Carroll									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster										c. LENGTH OF STAY IN b. HOURS										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Bridge									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RURAL										e. STREET ADDRESS R 140 18 So. MAIN ST										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) GEORGE K. BOSTIAN										4. DATE OF DEATH August 30, 1960										5. SEX Male									
6. COLOR OR RACE White										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH 4/21/1922									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER CONSTRUCTION										10b. KIND OF BUSINESS OR INDUSTRY MARYLAND										11. BIRTHPLACE (State or foreign country) U.S.									
13. FATHER'S NAME WILLIAM H. BOSTIAN										14. MOTHER'S MAIDEN NAME MARY GRIM										12. CITIZEN OF WHAT COUNTRY? U.S.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES										16. SOCIAL SECURITY NO. 217-18-8942										17. INFORMANT W. H. BOSTIAN, UNION BRIDGE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Arteriosclerotic coronary disease with old infarct MI of left anterior ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town)										20g. (County)										20h. (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE Russell S. Fisher										CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>										DATE SIGNED 8/31/60									
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																			
										Address (Street, city, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										22b. DATE THEREOF 9/2/60										22c. NAME OF CEMETERY OR CREMATORY WINTERS CEM									
23. FUNERAL DIRECTOR 1010 Harrison Ave Union Bridge										24a. REC'D BY REGISTRAR SEP 6 '60										24b. REGISTRAR'S SIGNATURE Arthur S. Hume									

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8988

08959

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6yrs. 9mos. 20days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13			
f. STREET ADDRESS 29 S. Washington St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Franklin Middle Carl Last Cummings				4. DATE OF DEATH Month August Day 26 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1929	
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months 30 Days 30 Hours 30 Min.		11. IF UNDER 24 HRS. Months 30 Days 30 Hours 30 Min.		12. IF UNDER 24 HRS. Months 30 Days 30 Hours 30 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Vincent Cummings				14. MOTHER'S MAIDEN NAME Barbara Kress			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-24-5896			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of pancreas with metastasis DUE TO (b) 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, psychotic, undifferentiated type.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from November 6, 1953 to August 26, 1960 , that (I) (we) last saw the deceased alive on August 25, 1960 , and that death occurred at 3:05AM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo				22b. DATE SIGNED 8/26/60			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 8-30-60			
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery				23d. LOCATION (City, town, or county) (State) Baltimore			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street				25a. REC'D BY REGISTRAR AUG 30 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. Kress							

10/20/70

CONFIDENTIAL

888

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10-25-70

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the cause of the delay, writing the word "prolonged" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

8989

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

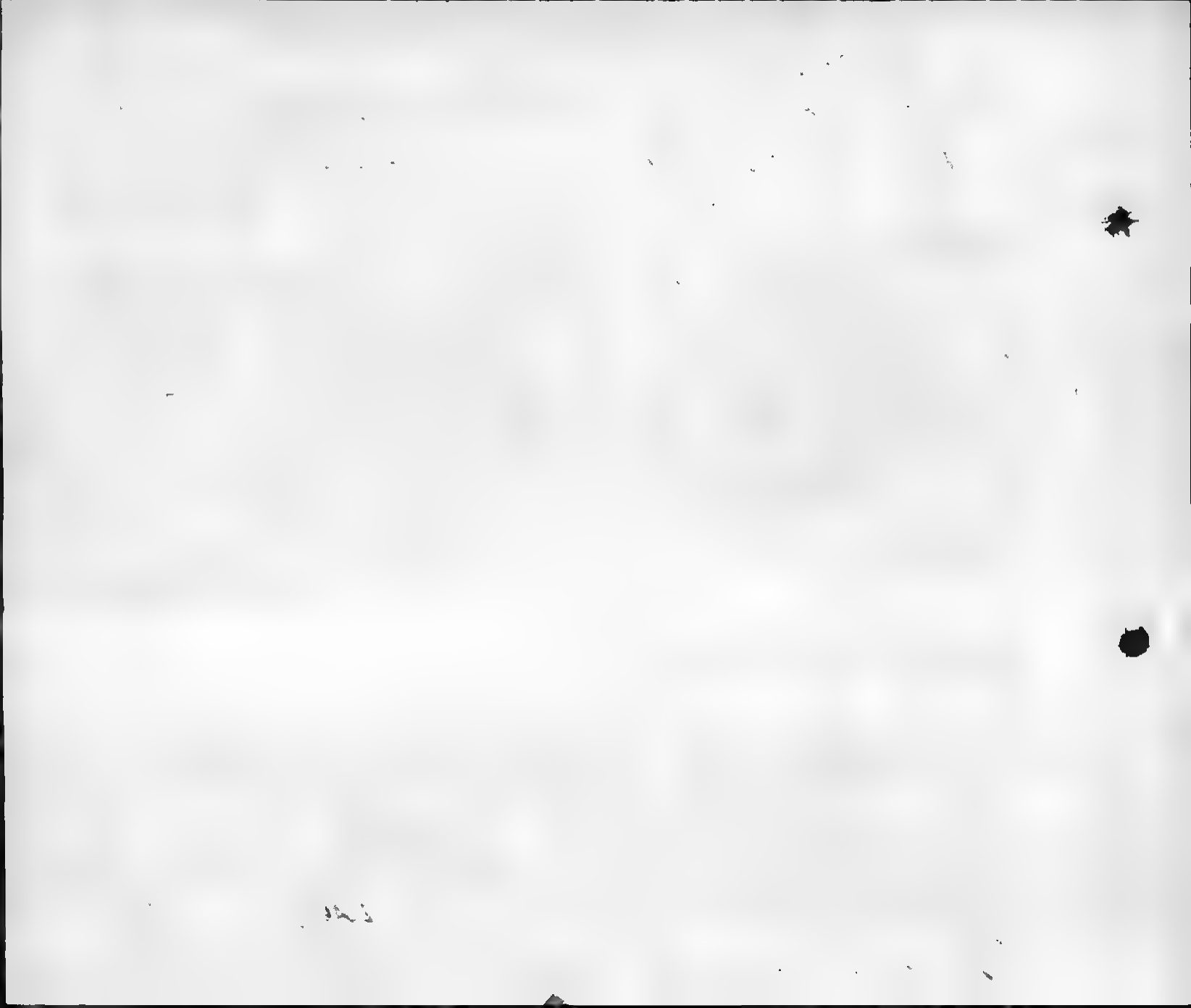
Reg. Dist. No.

05960

1. PLACE OF DEATH a. COUNTY CARROLL CO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE MARYLAND COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD		c. LENGTH OF STAY IN 1b 7 MIS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —				d. STREET ADDRESS DAVE RILL RD.			
3. NAME OF DECEASED (Type or print) First Middle Last EMMANUEL Bostick Cunningham				4. DATE OF DEATH Month Day Year Aug 20 1960			
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 1, 1888	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT CUNNINGHAM				14. MOTHER'S MAIDEN NAME MARY MCCARDEL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 705-05-7957		17. INFORMANT Address MRS. CUNNINGHAM HAMPSTEAD MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1 hr
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W. H. Foard				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. H. Foard M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/23/60		22c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE CEM.		22d. LOCATION (City, town, or county) (State) LAWAL MD.	
23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell Westminster MD				24a. REC'D BY REGISTRAR AUG 23 1960		24b. REGISTRAR'S SIGNATURE ...	

DATE SIGNED

Aug 21-1960



may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8990

08961

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 1 yr. 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived If institution Res. dence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12 d. STREET ADDRESS 723 Penninghaus Road e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle Finn Last du Bois				4. DATE OF DEATH Month August Day 3 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH February 17, 1905 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Finn				14. MOTHER'S MAIDEN NAME Ella Brannen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 214-01-7732		17. INFORMANT Springfield Hospital Records, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infected decubitus ulcers DUE TO Metastatic carcinoma in the liver and thoracic spine secondary to carcinoma of the breast. (c) Unknown				INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depressive Reaction				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 14, 1959 to August 3, 1960 , that (I) (we) last saw the deceased alive on August 3, 1960 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22b. DATE SIGNED August 3, 1960 22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/60		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk. Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. T. ... ADDRESS Baltimore - 12 Md				25a. REC'D BY REGISTRAR AUG 8 '60		25b. REGISTRAR'S SIGNATURE ...	



CERTIFICATE OF DEATH

08962
Reg. Dist. No.

8991

M

PLACE OF DEATH
a. COUNTY

Carroll

MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE

Maryland

b. COUNTY

Carroll

b. CITY OR TOWN (If outside corporate limits, write
RURAL, and give nearest town)

Rural - Sykesville

c. LENGTH OF STAY IN 1b

2yr. 1mo. 12days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Woodbine

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Springfield State Hospital

d. STREET ADDRESS

Route # 1

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Fannie

Middle

Louise

Last

ESCAVILLE

4. DATE
OF DEATH

Month

August

Day

23

Year

1960

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

2-5-86

9. AGE (In years
last birthday) yrs

74

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.
Hours Min10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry Sullivan

14. MOTHER'S MAIDEN NAME

Louisa Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

4th -

INFORMANT

Address

Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

ARTERIOSCLEROTIC Heart Disease
CORONARY Arteriosclerosis
Nephrosclerosis, chronicINTERVAL BETWEEN
ONSET AND DEATHyears
years
y+atConditions if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

DUE TO

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic brain syndrome associated with circulatory disturbance, with
cerebral arteriosclerosis, with psychotic reaction.19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day Year
Hour a. m.
p. m.20d. INJURY OCCURRED
While at work ☐ Not while
at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 7-11, 1958, to 8-23, 1960, that I last saw the deceased
alive on August 23, 1960, and that death occurred at 12 Noon, from the causes and on the date stated above

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Ilse Kamm, M. D.

M. D.

Springfield State Hospital

8-23-60

PHYSICIAN'S
NAME (Type)

Ilse Kamm, M. D.

Sykesville, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

August 26, 1960

22c. NAME OF CEMETERY OR CREMATORY

Lloyd Ridge

22d. LOCATION (City, town or county)

Pikesville, Baltimore Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

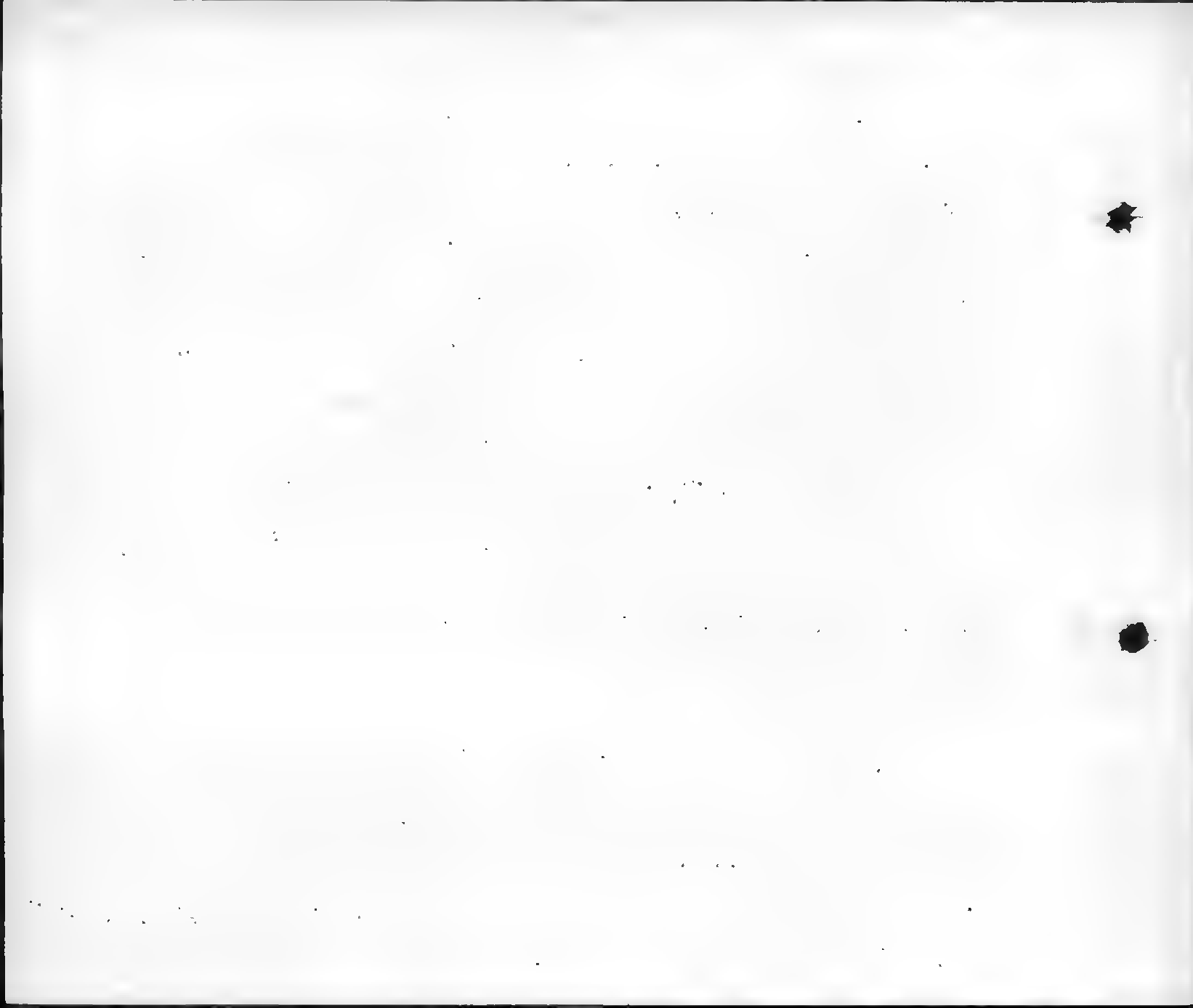
Arthur A. Haight, Sykesville, Md.

24a. REC'D BY REGISTRAR

AUG 29 '60

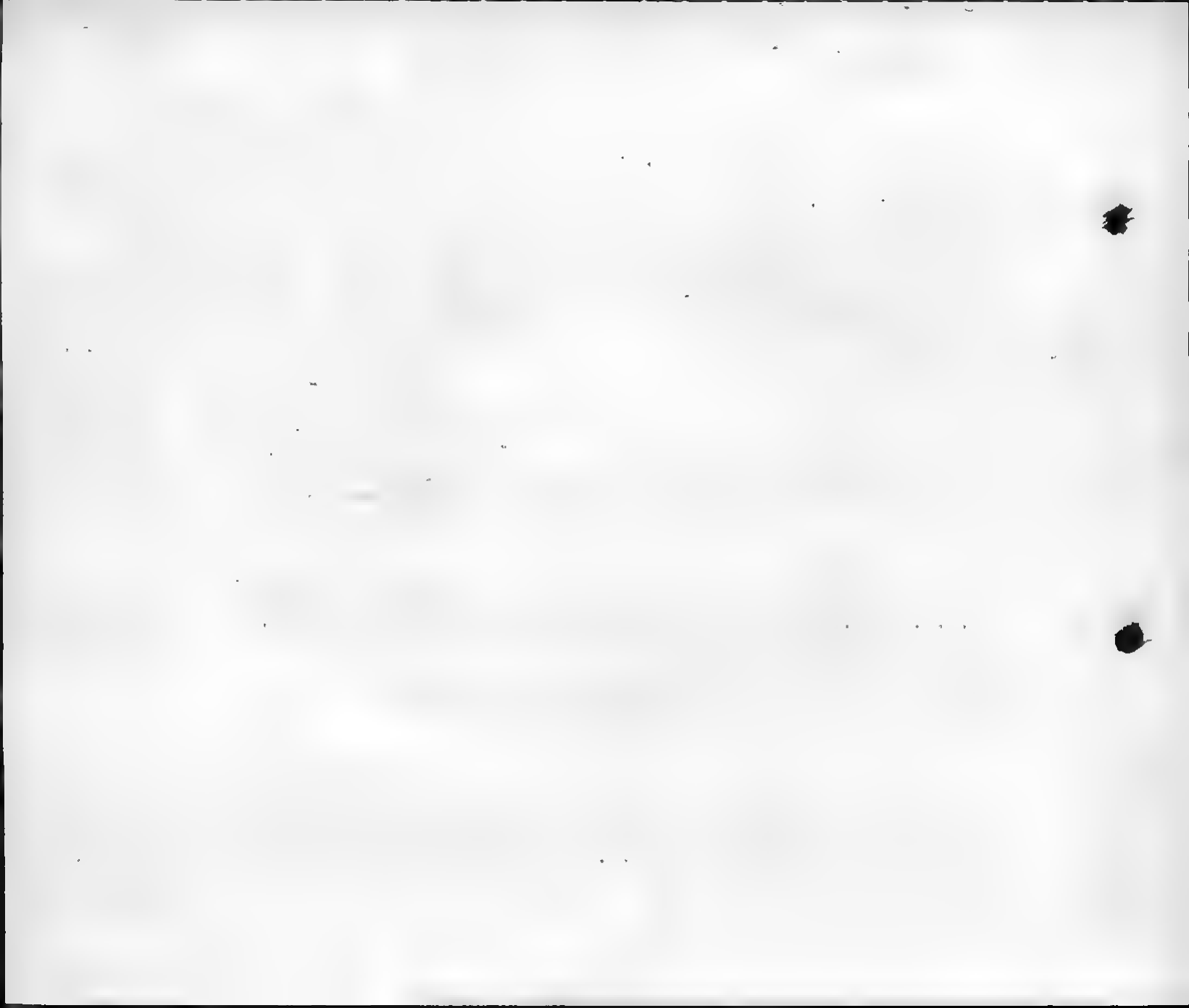
24b. REGISTRAR'S SIGNATURE

Charles S. Kinn



08963

1. PLACE OF BIRTH o COUNTY		Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If deceased lived in residence after death) a. STATE		Maryland		b. COUNTY		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Sykesville		c. LENGTH OF STAY IN 1b		4 mos. 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore 19		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Springfield State Hospital		d. STREET ADDRESS		1318 Forrest Road							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day	
Alfred				Evans				August		4,		1960	
5. SEX		Male		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		September 9, 1872	
				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. AGE (In years last birthday)		87 yrs	
										10. UNDER 1 YEAR		11. UNDER 24 HRS.	
										Months		Days	
										Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Unknown		10b. KIND OF BUSINESS OR INDUSTRY		-		11. BIRTHPLACE (State or foreign country)		Kentucky		12. CITIZEN OF WHAT COUNTRY?	
												U.S.A.	
13. FATHER'S NAME		Hyron Evans		14. MOTHER'S MAIDEN NAME		Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.		-		17. INFORMANT		Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Arteriosclerotic cardiovascular disease		422.1		DUE TO		Bronchopneumonia		INTERVAL BETWEEN ONSET AND DEATH	
		Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.						DUE TO				Years	
												Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		C.B.S. assoc. with senile brain disease with psychotic reaction.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
Hour		o. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
21. I certify that (I) (this hospital) attended the deceased from March 31, 1960 to August 4, 1960 that (I) (we) last saw the deceased alive on August 4, 1960, and that death occurred at 10:05 AM from the causes and on the date stated above													
22a. SIGNATURE		Agustin del Campo		M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED		8/4/60			
22c. PHYSICIAN'S NAME (Type)		Agustin del Campo, M.D.		22d. ADDRESS		Springfield Hospital, Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)					
BURIAL		8-6-60		Meadowridge		Baltimore		Md.					
24. FUNERAL DIRECTOR'S SIGNATURE		John J. Connelly		ADDRESS		Essex 21 Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
								DATE		AUG 8 '60		Charles S. House	



8993

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Community Hospital</u>		e. STREET ADDRESS <u>1000 N. 1st St.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN THOMAS FINKEL</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1880</u>
9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>11</u> Days <u>5</u> Hours <u>5</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George P. Fink</u>		14. MOTHER'S MAIDEN NAME <u>Kathleen Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Recurrent Cerebral Thrombosis</u> DUE TO <u>2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> (c) <u>None</u>		INTERVA. BETWEEN ONSET AND DEATH <u>5m</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1960</u> to <u>Aug 30, 1960</u> , that I last saw the deceased alive on <u>Aug. 30, 1960</u> and that death occurred at <u>12:45 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		DATE SIGNED <u>8/31/61</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept. 26</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Harford, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Thompson</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '60</u>	
ADDRESS <u>100 N. 1st St.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8982

CERTIFICATE OF DEATH

Reg. Dist. No. 08965

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>148 W. Main St.</u>				d. STREET ADDRESS <u>148 W. Main St.</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES RYLE</u> First Middle Last <u>FCUTZ</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 20, 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Practitioner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Practice</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Joseph Forth</u>			
14. MOTHER'S MAIDEN NAME <u>Mary R. Forth</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>148 W. Main St.</u>				17. INFORMANT <u>Charles R. Forth</u> Address <u>148 W. Main St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Chronic Myocarditis</u> (b) <u>Arteriosclerosis + Emaciation</u> (c) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August 1, 1960</u> , to <u>Aug 2, 1960</u> , that I last saw the deceased alive on <u>Aug 2, 1960</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles R. Forth</u>				ADDRESS (Street, city or town, state) <u>Westminster, Md</u>			
DATE SIGNED <u>5/3/60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. [illegible]</u>				24. REC'D BY REGISTRAR <u>AUG 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles R. Forth</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

08966

Reg. Dist. No.

8994

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Simsbury Rty</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Simsbury Rty #1</u>			
c. LENGTH OF STAY IN 1b <u>35 yrs</u>				d. STREET ADDRESS <u>Miller Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miller Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>GERALD</u> Last <u>FRIZZELL</u>				4. DATE OF DEATH Month <u>AUG</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 12, 1924</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & employee of Black & Decker</u>		11. BIRTHPLACE (State or foreign country) <u>West Carroll Pa. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM B. FRIZZELL</u>				14. MOTHER'S MAIDEN NAME <u>ELLA GERTRUDE GREEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-26-1945</u>			
17. INFORMANT <u>Mr. W. Gerald Frizzell Simsbury Md</u>				Address <u>RT 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>TO</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>20 MINUTES</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December, 1960</u> , to <u>August, 1960</u> , that I last saw the deceased alive on <u>August 17, 1960</u> , and that death occurred at <u>11:07 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Daniel I Welliver</u> M.D.				ADDRESS (Street, city or town, state) <u>19 RIDGE ROAD</u>		DATE SIGNED <u>8-17-60</u>	
PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>				WESTMINSTER MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr. Westminster, Md</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>AUG 22 '60</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

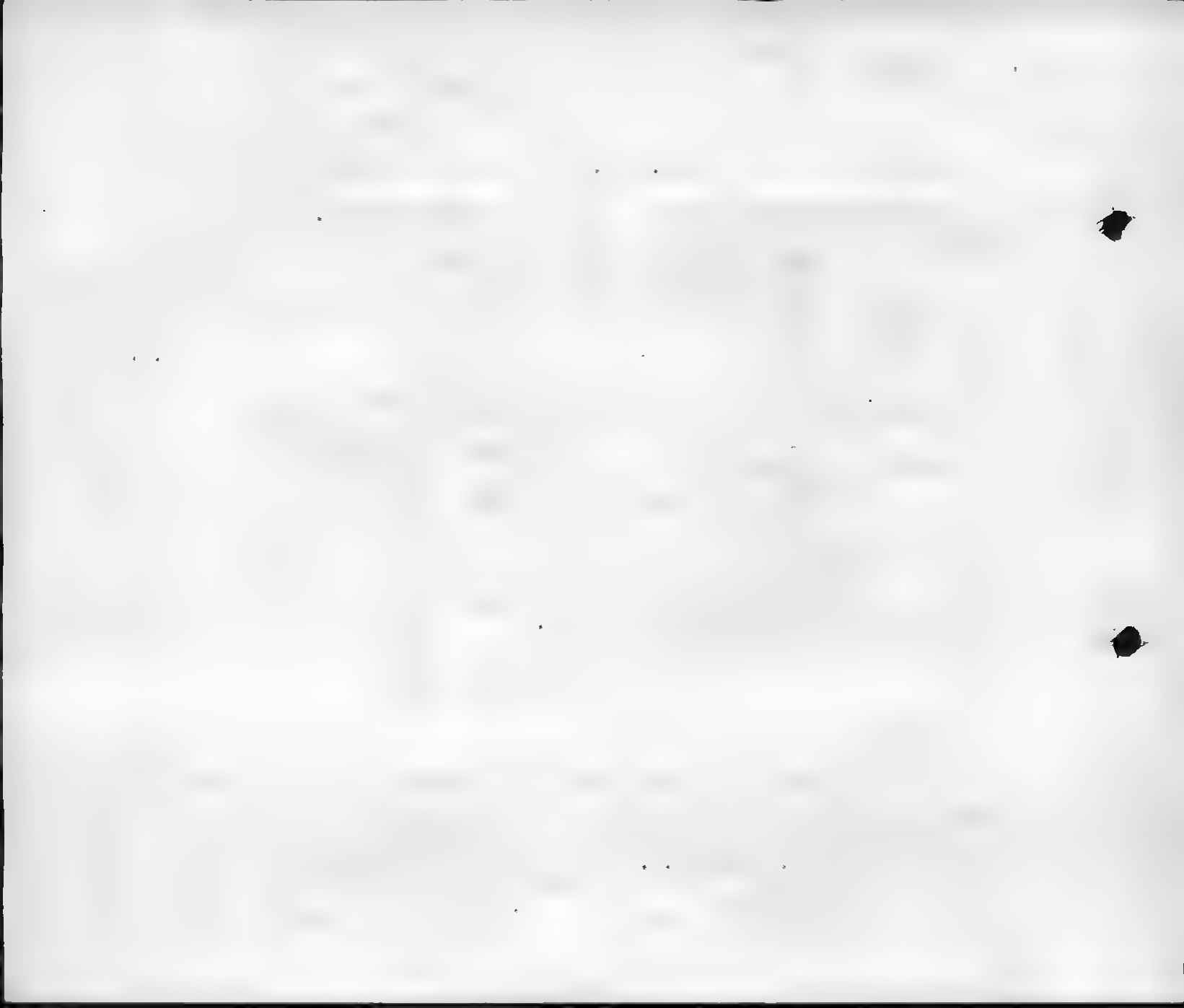
FOR STATE
HEALTH DEPT.

8995

68667

<p>1. PLACE OF DEATH a. COUNTY Carroll MARYLAND</p> <p>b. CITY OR TOWN (If built de corporate limits, write RURAL and give nearest town) Sykesville</p> <p>c. LENGTH OF STAY IN lb 1yr. 6mos. 9days</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital</p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before adm is on, a. STATE Maryland b. COUNTY Montgomery</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring</p> <p>d. STREET ADDRESS 12813 Matey Rd.</p> <p>e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) Mary Eloise Tonnar Garvey</p> <p>5. SEX Female</p> <p>6. COLOR OR RACE White</p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p> <p>13. FATHER'S NAME Michael Tonnar</p> <p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>4. DATE OF DEATH August 8, 1960</p> <p>8. DATE OF BIRTH July 26, 1918</p> <p>9. AGE (In years, last birthday) 42 yrs</p> <p>11. BIRTHPLACE (State or foreign country) Missouri</p> <p>14. MOTHER'S MAIDEN NAME Clara Phister</p> <p>17. INFORMANT Springfield Hospital Records</p> <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonia</p> <p>325X DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type.</p> <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20c. TIME OF INJURY Month, Day, Year 19</p> <p>Hour a. m. p. m.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)</p> <p>20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE James T. Marsh</p> <p>EXAMINER'S NAME (Type) James T. Marsh, M.D.</p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DATE SIGNED 8/8/60</p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p> <p>22b. DATE THEREOF Aug. 11, 1960</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.</p> <p>22d. LOCATION (City, town, or county) (State) Arlington Va</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE H. Don, Jr</p>		<p>24a. REC'D BY REGISTRAR Vol 2224-Wis. Ave. N.W.</p> <p>24b. REGISTRAR'S SIGNATURE Clifford S. Haines</p> <p>DATE AUG 15 '60</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.



may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

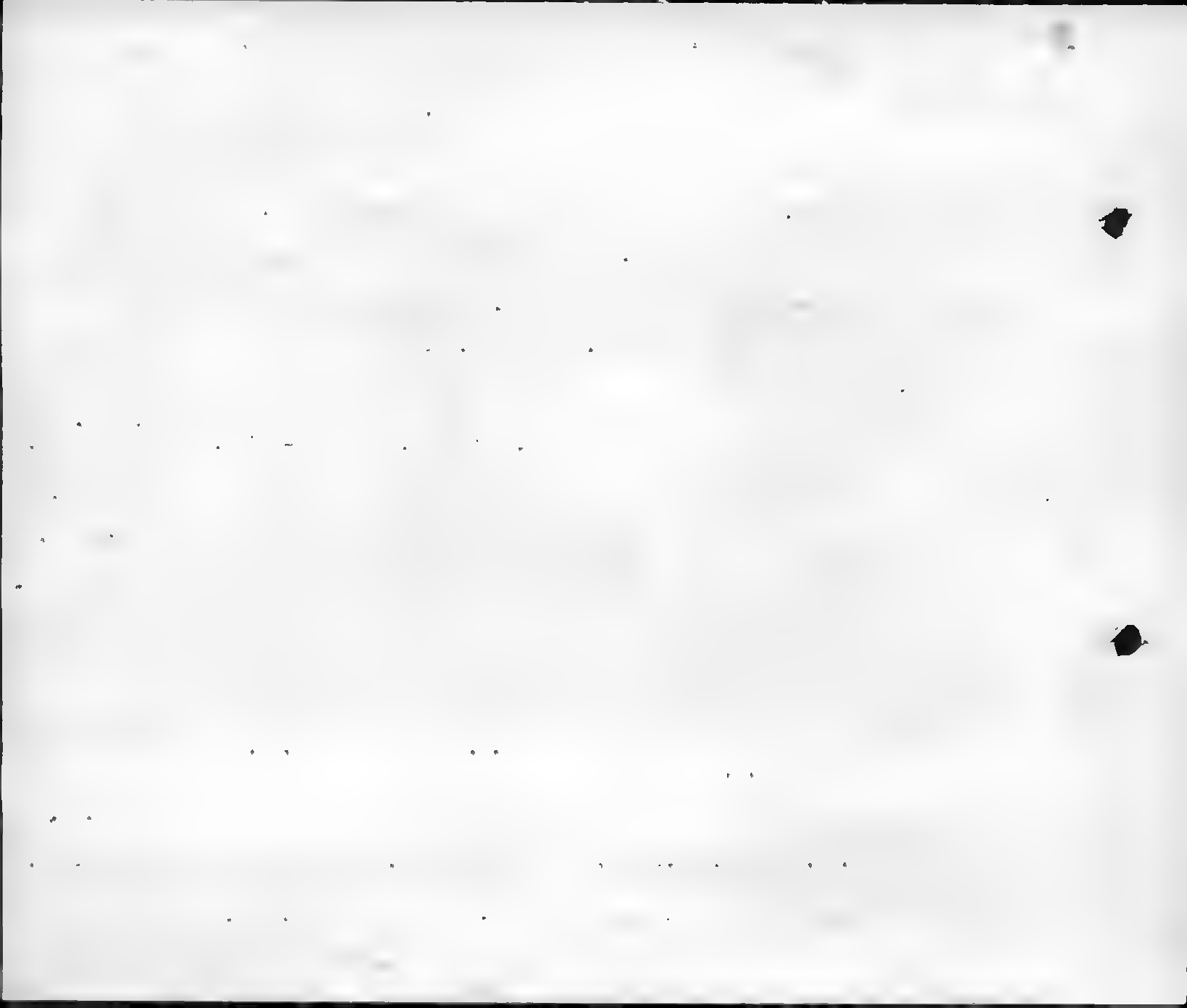
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8996

CERTIFICATE OF DEATH

08968

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - rural		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville - rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakland Mill Rd.		d. STREET ADDRESS Oakland Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle R. Last GISBURNE			4. DATE OF DEATH Month August Day 28 Year 1960		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1888	9. AGE (In years last birthday) 71 yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Owner		10b. KIND OF BUSINESS OR INDUSTRY Trucking Co.		11. BIRTHPLACE (State or foreign country) N. Y.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Gisburne			
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO		17. INFORMANT Edinhurst, Ill. Mr. Edward H. Gisburne-380 S. Kenilworth Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMBOLISM OF CORONARY ARTERY Conditions if any which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) HYPERTENSIVE CARDIOVASCULAR DISEASE					INTERVAL BETWEEN ONSET AND DEATH 20 min. 15-20 yrs. 40 plus yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1.9.60 to 8.28.60 , 19____, that () (we) last saw the deceased alive on 8.7.60 19____, and that death occurred at 10:30A on the causes and on the date stated above					
22a. SIGNATURE Wm. H. Lawson, Jr., M.D.		22b. DATE SIGNED 8.28.60		22c. PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.	
22d. ADDRESS Liberty Rd. nr Eldersburg, Sykesville, Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/31/60		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crem.	
23d. LOCATION (City town or county) (State) Balto., Md.		24. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Lickner			
25a. REC'D BY REGISTRAR Aug 30 '60		25b. REGISTRAR'S SIGNATURE Carl J. S. Hume			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

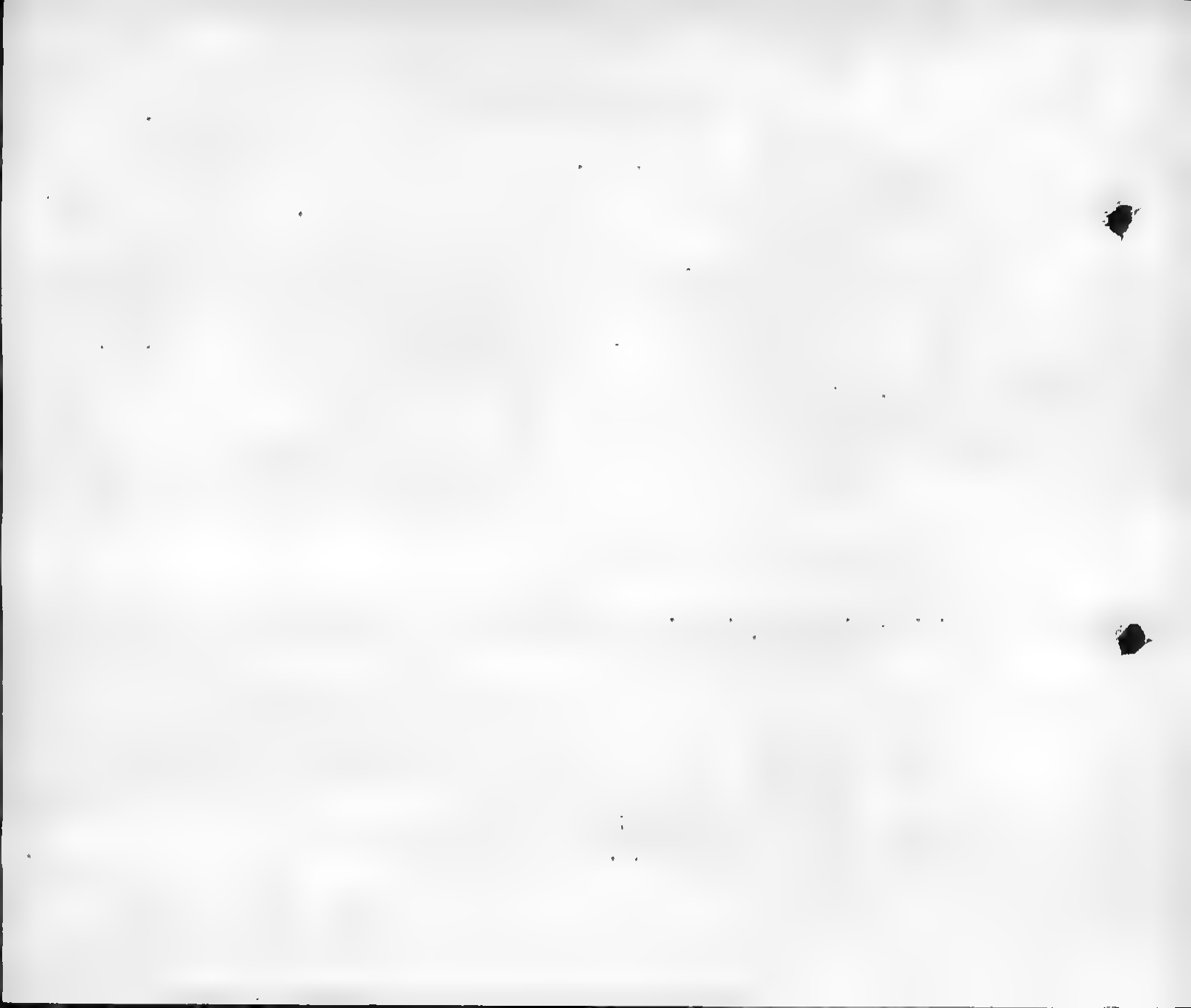
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8997

CERTIFICATE OF DEATH

08969

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 27yrs. 6mos. 10 days d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Balto. City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1321 Cambria St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Henry		4. DATE OF DEATH Month August Day 30 Year 1960	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 11, 1868
9 AGE (In years last birthday) 91		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pill maker		10b KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Henry L. Graf		14 MOTHER'S MAIDEN NAME Charlotte	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17 INFORMANT Springfield Hospital Records		Address	
18 CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute pancreatic duct abscess DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) G.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from March 7, 1955 , to August 30, 1960 , that (I) (we) last saw the deceased alive on August 29, 1960 , and that death occurred at 6:10AM from the causes and on the date stated above.			
22a SIGNATURE Agustin del Campo		22b DATE 8/30/60	
22c PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d ADDRESS Springfield State Hospital, Sykesville, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) B		23b DATE THEREOF 9-2-60	
23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d LOCATION (City, town, or county) (State) Brooklyn Md	
24 FUNERAL DIRECTOR'S SIGNATURE Miss Cheryl June 1308		25a REC'D BY REG STRAR SEP 1 '60	
ADDRESS For name		25b REGISTRAR'S SIGNATURE Arthur L. Hines	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8998

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08970

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2021 Osborn Drive			
3. NAME OF DECEASED (Type or print) First Harriet Middle Beulah Last Grier				4. DATE OF DEATH Month August Day 4 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1887	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months 73 Days 0 Hours 0 Min 0	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. C. T. ZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM T. GRIER				14. MOTHER'S MAIDEN NAME Harriet Harkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT Springfield Hospital Records, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 33.0 DUE TO Confluent bronchopneumonia Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost } (b) Metastatic carcinoma to the liver Months DUE TO (c) Carcinoma of the cecum Months							INTERVAL BETWEEN ONSET AND DEATH 24 hours.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease, with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 31, 1960 to August 4, 1960 , that (I) (we) last saw the deceased alive on August 4, 1960 , and that death occurred at 4:10 A.M. the causes and on the date stated above							
22a. SIGNATURE <i>Agustin del Campo</i>				22b. DATE August 4, 1960		22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22d. ADDRESS Springfield State Hosp., Sykesville, Md.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-6-60		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home</i>				24a. ADDRESS 4812 Ga Ave NW DC		24b. REC'D BY REGISTRAR DATE AUG 9 '60	
24c. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>				24d. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or entombment and in any case with a funeral home or funeral director.

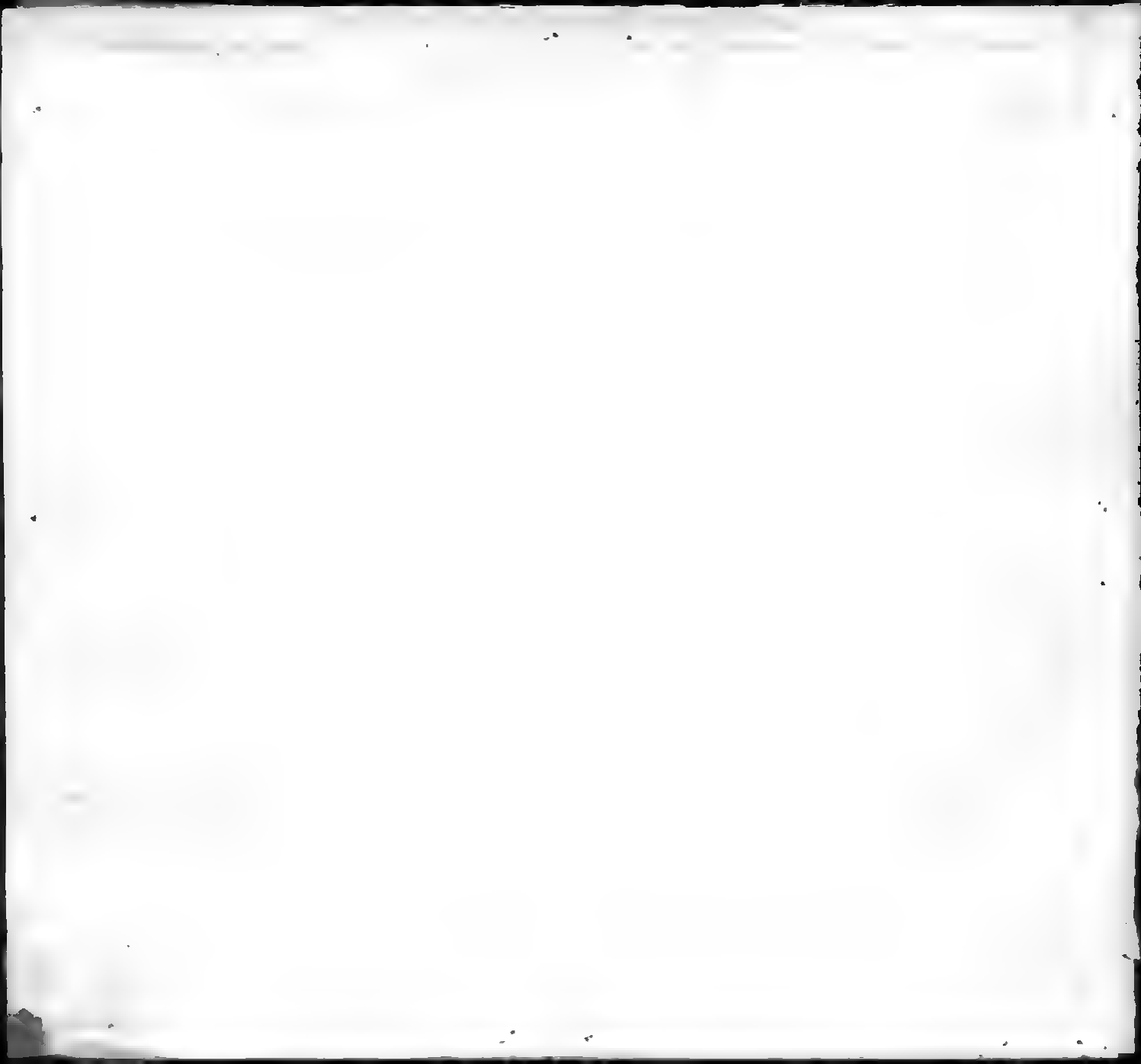
8999

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08971

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND			2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keymar		c. LENGTH OF STAY IN lb Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Keymar		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharret Road			d. STREET ADDRESS Sharret Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Laura Middle Virginia Last Hahn			4 DATE OF DEATH Month August Day 11 Year 1960		
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1877		9 AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Samuel Angell			14 MOTHER'S MAIDEN NAME Mary Brown		
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-40-5984	17 INFORMANT Address Miss Thelma Hahn, Keymar, Md.. R.D.		
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General debility DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 7 days 7 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21 I certify that (I) (this hospital) attended the deceased from Jan 6, 1960 to Aug 10, 1960 that (I) (we) last saw the deceased alive on Aug 10, 1960 and that death occurred at 2 AM , from the causes and on the date stated above					
22a. SIGNATURE J. N. Legg		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED Aug. 12, 1960	
22c PHYSICIAN'S NAME (Type) T. H. LIEGG MD		22d ADDRESS Union Bridge Md			
23a BURIAL, CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF Aug. 13, 1960	23c NAME OF CEMETERY OR CREMATORY Keysville Cemetery		23d LOCATION (City, town, or county) (State) Keysville, Carroll, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE C. G. Fuss & Son, ADDRESS Taneytown, Maryland			25a REC'D BY REGISTRAR DATE AUG 15 '60	25b REGISTRAR'S SIGNATURE Charles S. Kline	

MEDICAL CERTIFICATION



1-1 Film 278 1-1-1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
9000 **CERTIFICATE OF DEATH** **08972**

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND		2 USUAL RESIDENCE (Where deceased lived first full year; Residence before admission) a. STATE Wash., D.C. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Henryton State Hospital		e. STREET ADDRESS 8720 Livingston Road	
3 NAME OF DECEASED (Type or print) First Lucy Middle Ford Last Johnson		4 DATE OF DEATH Month August Day 24 Year 1960	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 5-29-1888
9 AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Brandywine, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Ford		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO Unknown	
17 INFORMANT Mamie Miller- 8720 Livingston Rd. Wash., D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 002X IDENTIC Part II Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular arteriosclerosis (c) Moderately advanced pulmonary tuberculosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town)		(County) (State)	
21 I certify that (I) (this hospital) attended the deceased from August 22, 1960 to August 24, 1960 , that (I) (we) last saw the deceased alive on Aug. 24, 1960 , and that death occurred on Aug. 24, 1960 at 6:35 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Edgars M. Maculans, Supt. M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans		22d. ADDRESS Henryton, Maryland	
23a. BURIAL, CREMATION, RENOVAL (Specify)	23b. DATE THEREOF 8-28-60	23c. NAME OF CEMETERY OR CREMATORY Church	23d. LOCATION (City, town, or county) (State) CHAPEL HILL MARYLAND
24 FUNERAL DIRECTOR'S SIGNATURE John T. Rhine Co		25a REC'D BY REGISTRAR 3015-12th St. N.E. D.C.	
25b REGISTRAR'S SIGNATURE John T. Rhine		DATE AUG 30 1960	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 25yrs. 10mos. 5 days Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 630 Cokesbury Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Charles Middle Killmon Last Killmon			4. DATE OF DEATH Month August Day 9 Year 19 60		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 9, 1899		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles W. Killmon			14. MOTHER'S MAIDEN NAME Elizabeth A. White		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUO TO <i>Due to Coronary arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUO TO <i>years</i> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>James T. Marsh</i>		EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-60		22c. NAME OF CEMETERY OR CREMATORY Springfield Hospital	
22d. LOCATION (City, town, or county) (State) Sykesville, Carroll, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. August</i>		24a. REC'D BY REGISTRAR DATE AUG 23 '60		24b. REGISTRAR'S SIGNATURE <i>Robert A. August</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your records. Prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

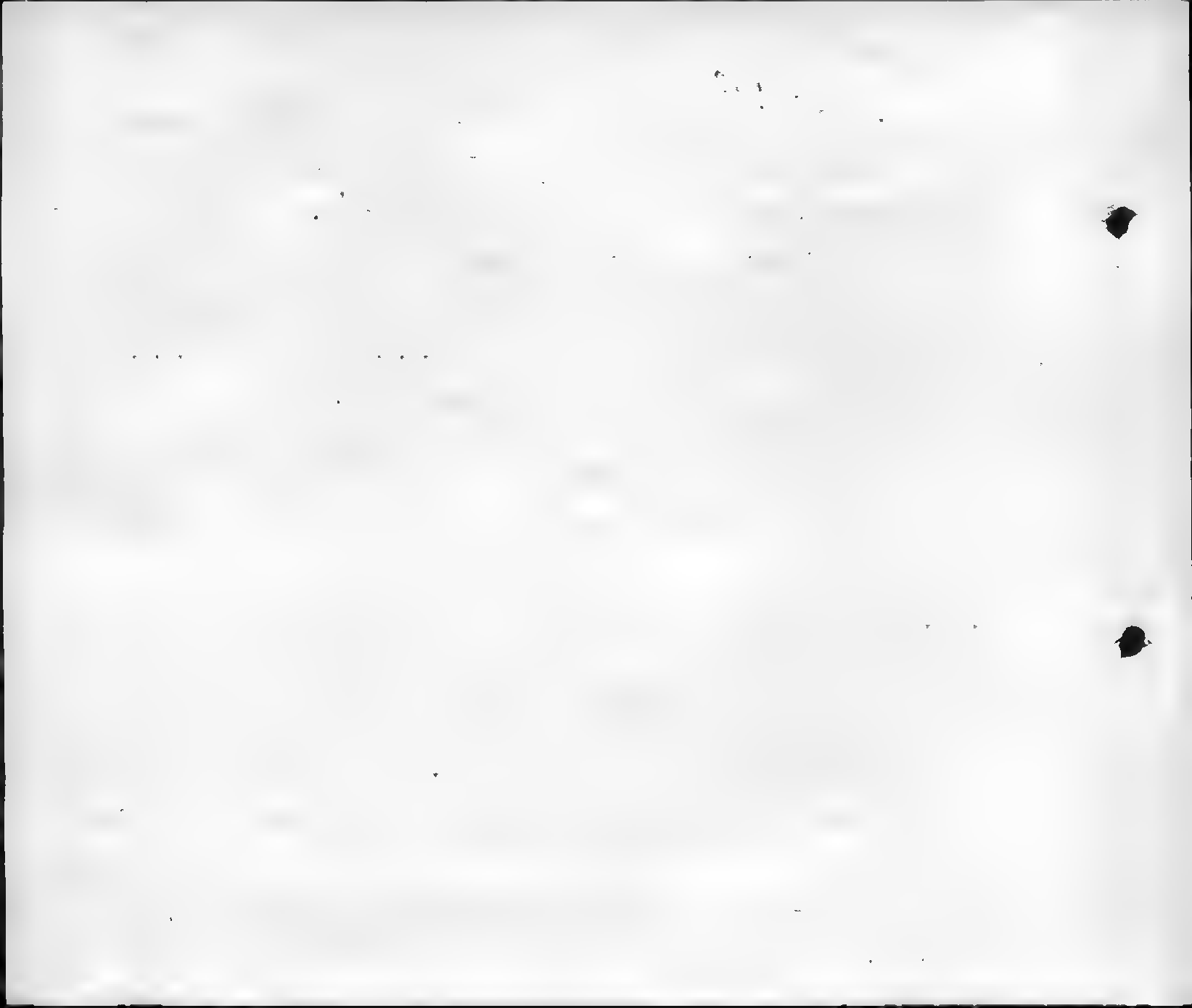
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9002

08974

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesville		c. LENGTH OF STAY IN 1b 2 mos. 16 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City, 30	
3. NAME OF DECEASED (Type or print) William Edward Little		4. DATE OF DEATH 8 26 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/90
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Racetrack guard		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Elizabeth O. ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes W W I		16. SOCIAL SECURITY NO 218225872	
17. INFORMANT Springfield State Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure			
DUPLICATE TO Bilateral Pneumonia			
DUPLICATE TO			
DUPLICATE TO			
DUPLICATE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with Senile Brain Disease			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/10/1960 to 8/26/1960 , that (I) (we) last saw the deceased alive on 8/26 1960 , and that death occurred at 5:45 p M, from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 8/26/1960	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) burial		23b. DATE THEREOF 8-29-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		25a. REC'D BY REGISTRAR AUG 30 '60	
ADDRESS 5305 Hargord Rd.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



9003

CERTIFICATE OF DEATH

08975
Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <u>Harroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) b. COUNTY <u>Harroll</u> STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamptstead Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hamptstead (Rural)</u>	
c. LENGTH OF STAY IN 1b <u>5 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>METTIE - J - LUDWIG</u>		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30 - 1877</u>
9. AGE (In years last birthday) <u>83</u>		10. F UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edmund Reed</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>910</u>	
17. INFORMANT <u>Benny Croft</u>		Address <u>Hamptstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Antemortem</u> DUE TO (b) <u>Antemortem</u> DUE TO (c) <u>Antemortem</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>19</u> Hour <u>0</u> m. <u>0</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Ford</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Ford M.D.</u>		DATE SIGNED <u>8-29-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-31-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Harroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw & Lipton</u>		ADDRESS <u>Hamptstead Md</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

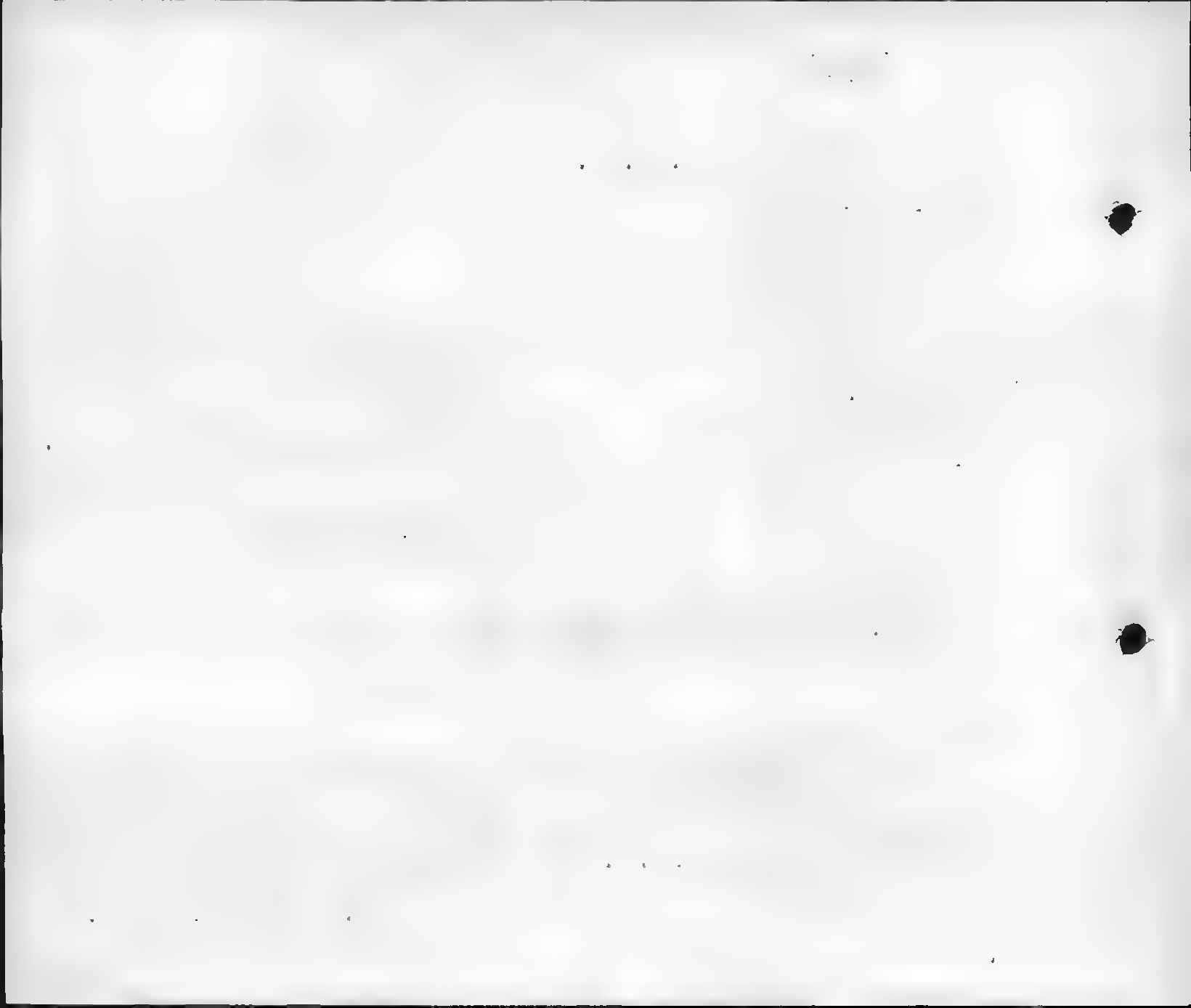
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9004

08976

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 5y. 3m. 1d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d STREET ADDRESS 871 Park Avenue				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Mamie Middle Josephine Last Martin				4 DATE OF DEATH Month 8 Day 19 Year 1960			
5 SEX female		6 COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/3/78	
9 AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12 CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) Decorator				10b. KIND OF BUSINESS OR INDUSTRY Interior decorator			
11. BIRTHPLACE (State or foreign country) Maryland				12 CITIZEN OF WHAT COUNTRY? USA			
13 FATHER'S NAME Alexander T. Martin				14. MOTHER'S MAIDEN NAME Mary Wilson			
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Springfield Hospital records, Sykesville, Md.				Address			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral hemorrhage							
DUE TO Arteriosclerotic cardio-vascular disease							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with disturbance of metabolism, growth or nutrition, with							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) senile brain disease			
20c. TIME OF INJURY Month. Day Year Hour a m p m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/18/1955 to 8/19/1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/19/1960 , and that death occurred at 8:35 AM , from the causes and on the date stated above							
22a. SIGNATURE Konstantin Weber				22b. DATE SIGNED 8/19/60			
22c. PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.				22d. ADDRESS Sykesville, Maryland			
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 8/22/60		23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery		23d. LOCATION (City, town or county) (State) St. Mary's City, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY				25a. REC'D BY REGISTRAR LEONARD TOWN, MARYLAND			
25b. REGISTRAR'S SIGNATURE Arthur L. K...				DATE AUG 23 '60			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9005

08977

1 PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Eldersburg c. LENGTH OF STAY IN 1b 11 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Liberty Rd., P.O. Sykesville		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admiss on) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Eldersburg d. STREET ADDRESS Liberty Rd., P.O. Sykesville e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) First ROBERT Middle GEORGE Last MILLER		4. DATE OF DEATH Month August Day 4, Year 19 60				
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1877	9. AGE (in years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min 83	11. IF UNDER 24 HRS Months 83 Days 83 Hours 83 Min 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Visible Equipt.		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? England ✓
13. FATHER'S NAME Harry Miller		14. MOTHER'S MAIDEN NAME Mary P. Harding		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 577-09-9519		
16. SOCIAL SECURITY NO 577-09-9519		17. INFORMANT Mr. Clarence C. Carty,		Address 54 E. Patrick Frederick, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis, left hemisphere DUE TO Arteriosclerosis generalized, conclusive DUE TO pneumonia, pneumonia - CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last INTERVAL BETWEEN ONSET AND DEATH July 60 to 4 Aug 60						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 21 July 1960 to 4 Aug 1960 , that (I) (we) last saw the deceased alive on 4 Aug 1960 , and that death occurred at 4 Aug 1960 M, from the causes and on the date stated above.						
22a. SIGNATURE Howard E. Hall		M. D. Howard E. Hall		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4 Aug 60
22c. PHYSICIAN'S NAME (Type) Howard E. Hall		M. D. M. D.		22d. ADDRESS Frederick, Md		
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF Aug. 6, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland		25a. REC'D BY REG STRAR AUG 8 '60		25b. REGISTRAR'S SIGNATURE Charles E. Thomas

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CP



9006

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harwell</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harwell</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge Rural</u>			c. LENGTH OF STAY IN 1b <u>1 yr</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>MAE</u> Last <u>MINNICK</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1960</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 8 - 1897</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. JSUA, OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Richard F. Robinson</u>			
14. MOTHER'S MAIDEN NAME <u>Rosa F. Ravenscroft</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-16-2398</u>		17. INFORMANT <u>Mrs Fred Spalla Union Bridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> 174X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Original site - uterus</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Harwell</u>	(County) <u>Harwell</u>	(State) <u>MD</u>
21. I certify that I attended the deceased from <u>11/5/59</u> , 19 <u>59</u> , to <u>8/2/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/31/60</u> , 19 <u>60</u> , and that death occurred at <u>1:40 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>M.E. Robertson</u> M.D.			ADDRESS (Street, city or town, state) <u>Harwell Harwell Md</u>		
PHYSICIAN'S NAME (Type) <u>M.E. Robertson</u>			DATE SIGNED <u>8/2/60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 5 - 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Harwell MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>			24a. REC'D BY REGISTRAR <u>Aug 4 '60</u>		
ADDRESS <u>Hampstead Md</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 PARK AVE.		e. STREET ADDRESS 23 PARK AVE	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last	
MARY VIRGINIA MOONEY		4. DATE OF DEATH Month Day Year Aug 6 1960	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3 1895	
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
11. BIRTHPLACE (State or foreign country) EASTON, PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MOONEY		14. MOTHER'S MAIDEN NAME NORA AMBROSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 205-26-8759	
17. INFORMANT MRS. EDWIN KRADE		Address 137 MAIN ST MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA RECTUM - PERITONEAL METASTASIS 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-19-1959, to 8-6-1960, that I last saw the deceased alive on 8-6-1960, and that death occurred at 10 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 105 E MAIN ST 8-6-60	
ACTUAL SIGNATURE James J Marsh M.D.		PHYSICIAN'S NAME (Type) JAMES T. MARSH WESTMINSTER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL		AUG 10, 60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
GETHSEMANE CEMETERY EASTON, PENNA.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
J. E. ...		24a. REC'D BY REGISTRAR DATE AUG 9 '60	
24b. REGISTRAR'S SIGNATURE		Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9007 Items 7, 11, 19-14, 20 et
CERTIFICATE OF DEATH

18980

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Sykesville		c. LENGTH OF STAY IN 1b 7yr. 9mo. 07d.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 954 LaVale St.	
3. NAME OF DECEASED (Type or print) Earl First Upton Middle Myers Last		4. DATE OF DEATH Month 8 Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-7-02
9. AGE (In years last birthday) 58 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad blacksmith		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Maryland, Hagerstown		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Myers		14. MOTHER'S MAIDEN NAME DESSIE Dessie Johns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown no		16. SOCIAL SECURITY NO 705-10-6598	
17. INFORMANT Records Springfield State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningoencephalitis 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with central nervous system syphilis, meningo-encephalitis with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- 19 p. m. ---		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-1957 , 19 Aug. 28 , 19 60 that I last saw the deceased alive on Aug. 28 , 19 60 , and that death occurred at 8:25 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Yasuo Takahashi		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Yasuo Takahashi, M.D.		DATE SIGNED 8-28-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8-31-60	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE AUG 31 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Friend	

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of nervous system

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Aug. 58

Sprinkling

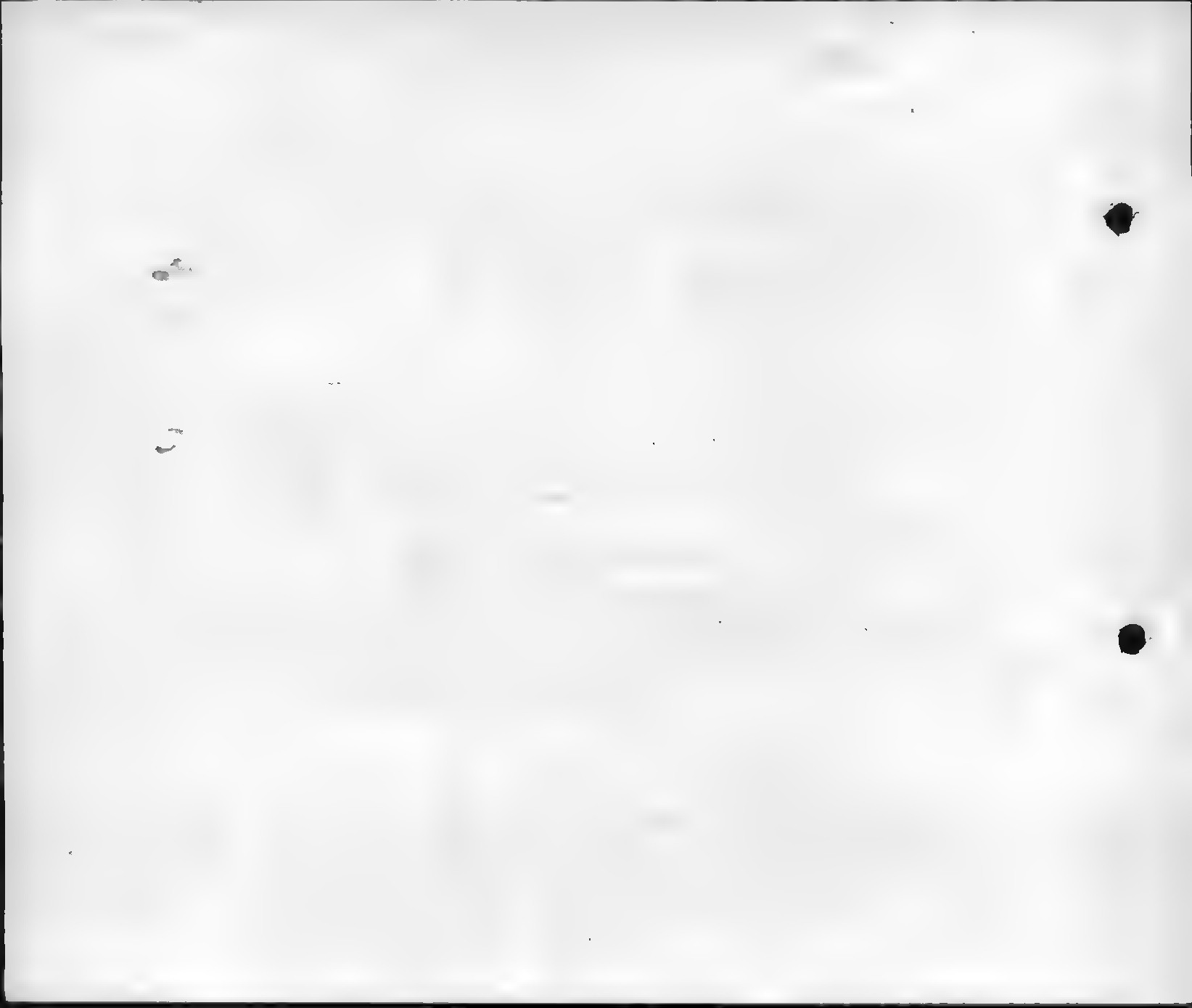
Sykes.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be attached for use in the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9008
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08981

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY (In 1b) 8 months 21 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2914 North Wind Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Frederick Last Neubert		4. DATE OF DEATH Month 8 Day 27 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1878
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Paper Box Co.	11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LUDWIG NEUBERT	
14. MOTHER'S MAIDEN NAME CHARLINE MEINERT		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 212-10-3026		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suppurative bilateral Nephritis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-6-59 to 8-27-1960 , that (I) (we) last saw the deceased alive on 8-27-1960 , and that death occurred at 2:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Agustin Del Campo M.D.		22b. DATE 8/27/60	
22c. PHYSICIAN'S NAME (Type) Agustin Del Campo		22d. ADDRESS Springfield Hospital, Sykesville, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/31/60	23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM	23d. LOCATION (City, town, or county) (State) BALTO CO MD
24. FUNERAL DIRECTOR'S SIGNATURE Chas F. Evans & Son		25a. REC'D BY REGISTRAR 8802 HARTFORD RD	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans		DATE AUG 31 '60	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

108982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D.1 Knoxville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRINGFIELD STATE HOSPITAL</u>				d. STREET ADDRESS <u>Petersville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORINE SHANK CRNDREFF</u>				4. DATE OF DEATH Month Day Year <u>8 20 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1902</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>11 25</u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES E. SHANK</u>				14. MOTHER'S MAIDEN NAME <u>CLARA BELL MILLMERT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Address <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RHEUMATIC OR MITRAL HEART DISEASE</u> + <u>PULMONARY EDEMA</u> DUE TO <u>INSULIN SHOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James J. March</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED <u>8/27/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>8-23-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>		22d. LOCATION (City, town, or county) (State) <u>Greenock Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. March</u>				ADDRESS <u>St. Luke's</u>		24a. REC'D BY REGISTRAR <u>8-27-60</u>	
				24b. REGISTRAR'S SIGNATURE <u>James J. March</u>			



9010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster 56 yrs</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster</u>				d. STREET ADDRESS <u>Westminster</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE ADELINE PELTZ</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 28 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 27, 1903</u>	9. AGE (In years last birthday) yrs. <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ELWOOD E. SNADER</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE B. NUSBAUM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-24-540</u>		17. INFORMANT Address <u>HUSBAND <u>Robert M. Peltz</u> <u>19 Ridge Rd. Westminster, Md.</u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF THE OVARY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>16 MOS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 14, 1959</u> to <u>AUG. 28, 1960</u> , that I last saw the deceased alive on <u>AUG. 28, 1960</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Lewis Stewart, M.D.</u>				ADDRESS (Street, city or town, state) <u>19 RIDGE RD. WESTMINSTER, MD.</u>		DATE SIGNED <u>AUG. 28, 1960</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM LEWIS STEWART</u>				<u>WESTMINSTER, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial Westminster</u>		<u>Aug 28 1960</u>		<u>Westminster</u>		<u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hines</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled out by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

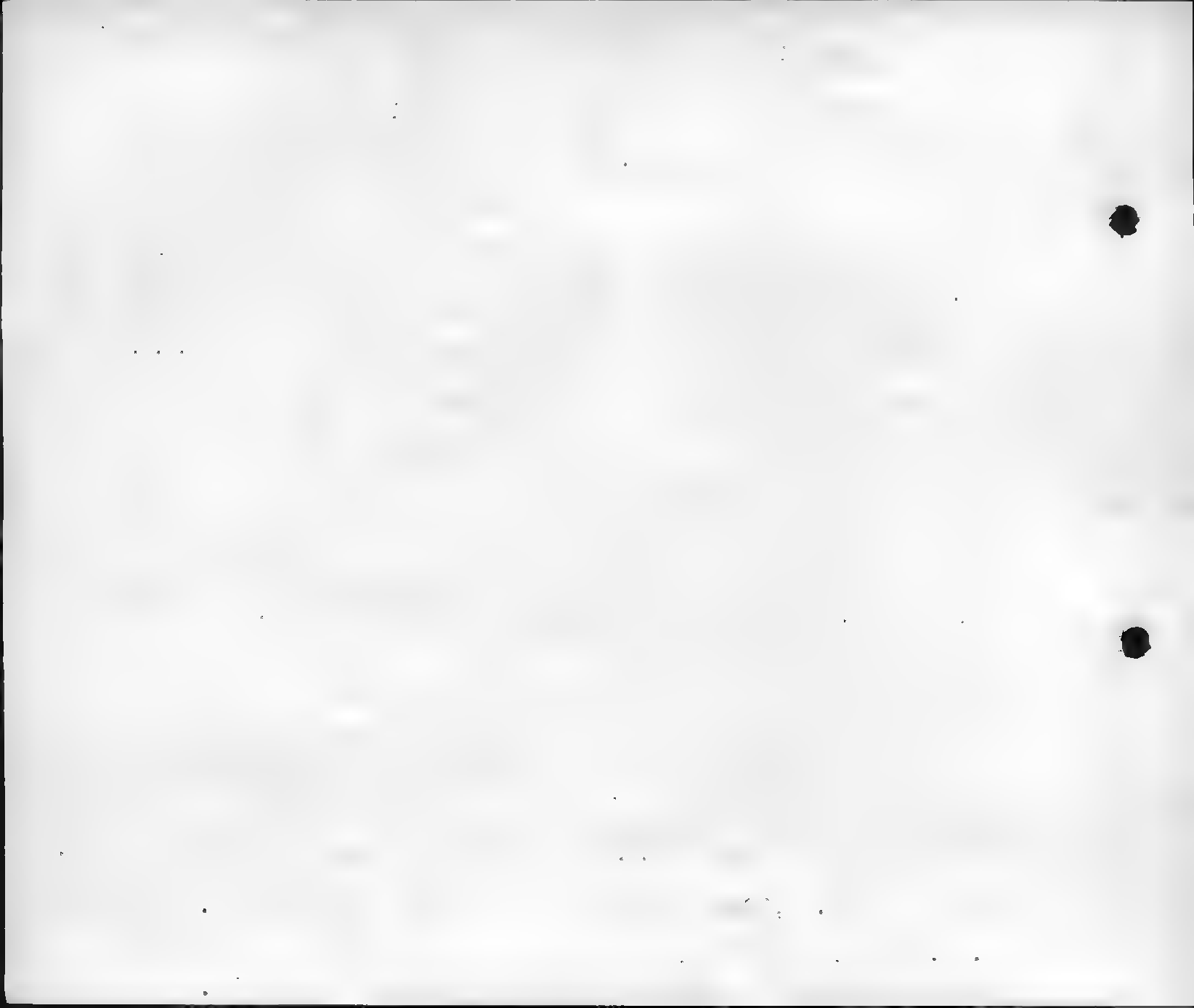
1

9011

08984

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN lb 5 mos. 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Route #1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Hatfield Porter				4. DATE OF DEATH Month August Day 21 , Year 1960			
5. SEX Female	6. CO. OR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1884		9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. M n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Amelia Porter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.B.S. assoc. with senile brain disease with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a m p m 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 18, 1960 to August 21, 1960 , that (I) (we) last saw the deceased alive on August 21, 1960 , and that death occurred at 6: P M. from the causes and on the date stated above							
22a. SIGNATURE <i>Agustin del Campo</i>				22b. DATE SIGNED 8/22/60			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 24, 1960		23c. NAME OF CEMETERY OR CREMATORY Taylorville Cemetery		23d. LOCATION (City town or county) (State) Carroll Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland				25a. REC'D BY REGISTRAR AUG 24 60		25b. REGISTRAR'S SIGNATURE <i>C. M. Waltz</i>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9012

08385

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middleburg		c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brookfield Manor Nursing Home				d. STREET ADDRESS 63 York Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Isaiah Middle Lewis Last Reifsnider				4. DATE OF DEATH Month August Day 13 Year 1960			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH March 3, 1872	
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min 13		IF UNDER 24 HRS. Months 13 Days 13 Hours 13 Min 13			
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Isaiah William Reifsnider				14 MOTHER'S MAIDEN NAME Rebecca Lippy			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO None		17. INFORMANT Mr. Raymond Reifsnider, Hanover, Pennsylvania			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration 15 yrs. 420 DUE TO (b) Coronary Arteriosclerosis 15 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Generalized Arteriosclerosis, Chronic Cystitis, & Prostatitis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I, (a) Generalized Arteriosclerosis, Chronic Cystitis, & Prostatitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 11/17/41 19 to 8/13/60 19 that (I) (we) last saw the deceased alive on 8/13/60 19 and that death occurred at 9:35 A.M. EST. from the causes and on the date stated above.							
22a. SIGNATURE R. S. McVaugh		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED AUG 15, 1960			
22c. PHYSICIAN'S NAME (Type) R. S. McVaugh		22d. ADDRESS Taneytown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 16, 1960		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City, town or county) (State) Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son				ADDRESS Taneytown, Maryland		25a. REC'D BY REGISTRAR DATE AUG 17 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thayer			

(M)

(I)



9015

CERTIFICATE OF DEATH

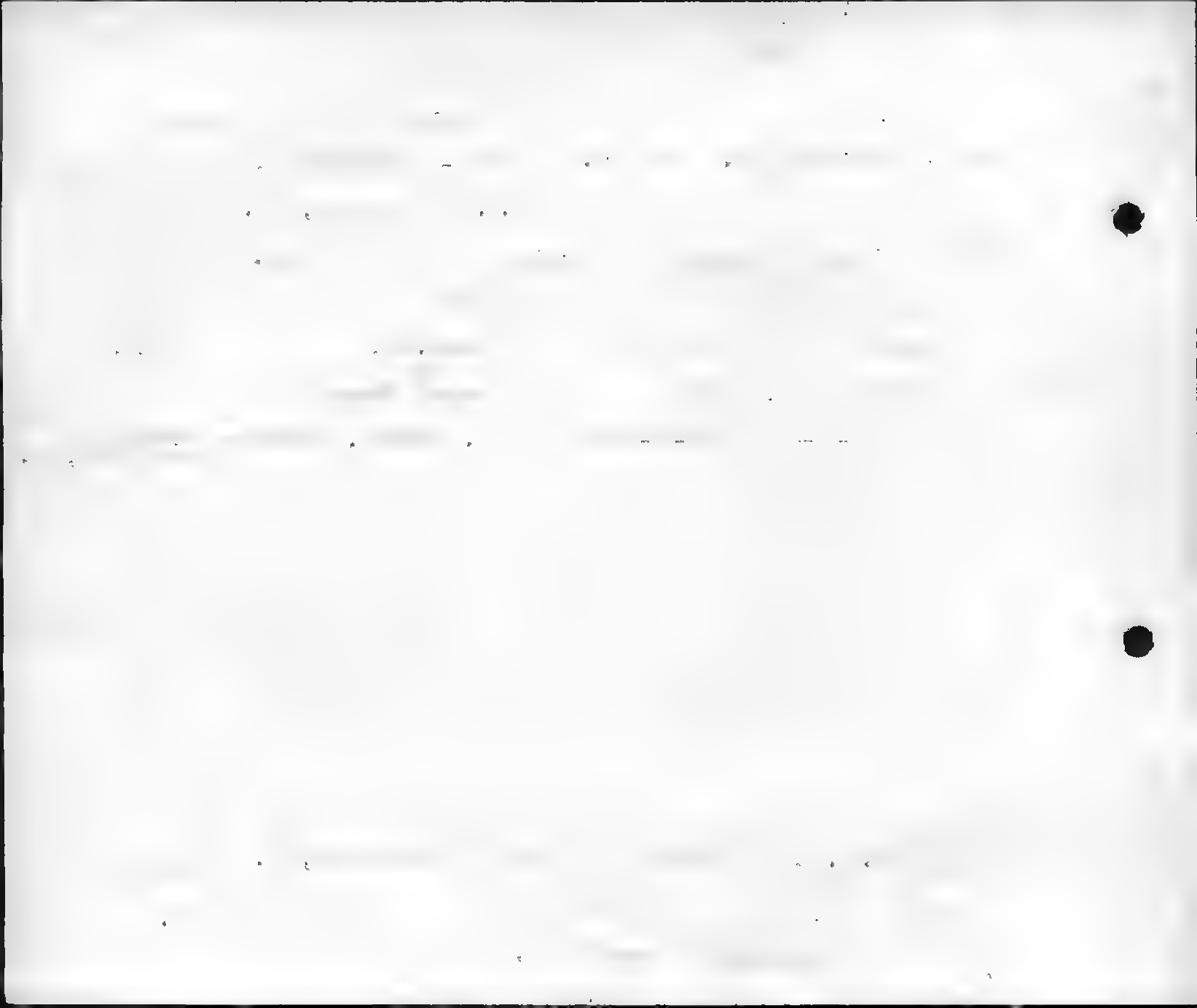
08988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived f. instit. or Residence before admision) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (f. outside corporate limits, write RURAL and give nearest town) Rural - Westminster, Md.		c. LENGTH OF STAY IN Tb 43 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Westminster, Md.	
		a. STREET ADDRESS R.D.#6 Westminster, Md.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Edward Sitterding		4. DATE OF DEATH Aug. 13 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1883
9. AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY poultry	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William Sitterding		14. MOTHER'S MAIDEN NAME Louise Besser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 220-34-7076	
17. INFORMANT son Mr. Edward G. Sitterding		Address R.D.#6 Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cerebral hemorrhage			
331X DUE TO Vascular disease			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) senility			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 12 , 19 60 to Aug. 13 , 19 60 that I last saw the deceased alive on Aug. 12 , 19 60 , and that death occurred at 6:30 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. L. Billingslea		ADDRESS (Street, city or town, state) M.D. Westminster, Md.	
PHYSICIAN'S NAME (Type) Dr. C. L. Billingslea		I S. Center St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/16/60	
22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Smallwood Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Safford Jr.		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR DATE AUG 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

9013

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08386

1 PLACE OF DEATH a. COUNTY Carroll MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown				c. LENGTH OF STAY IN 1b 60 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown			
f. STREET ADDRESS				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Samuel Middle David Last Snider				4. DATE OF DEATH Month August Day 21 Year 19 60			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH January 4, 1874		9. AGE (In years last birthday) 86 yrs	10. UNDER 1 YEAR IF UNDER 24 HRS Months 86 Days 86 Hours 86 Min 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day Labor		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William A. Snider				14. MOTHER'S MAIDEN NAME Alice Bower			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO No		17 INFORMANT Address Mrs. Carl Baumgardner, Littlestown, Penna.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a m p m 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 8/24 19 59 to 8/21 19 60 , that (I) (we) last saw the deceased alive on 8/15 19 60 , and that death occurred at 1000 M, from the causes and on the date stated above.							
22a SIGNATURE L. L. Potter		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 8/22/60			
22c PHYSICIAN'S NAME (Type) L. L. POTTER M.D.		22d ADDRESS LITTLESTOWN, PA.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 24, 1960		23c. NAME OF CEMETERY OR CREMATORY Harney Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Harney, Carroll, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Mercofus & Sons G.O. Fuss & Son,				25a. REC'D BY REGISTRAR DATE AUG 25 '60		25b. REGISTRAR'S SIGNATURE James S. Kline	
ADDRESS Taneytown, Md.							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.

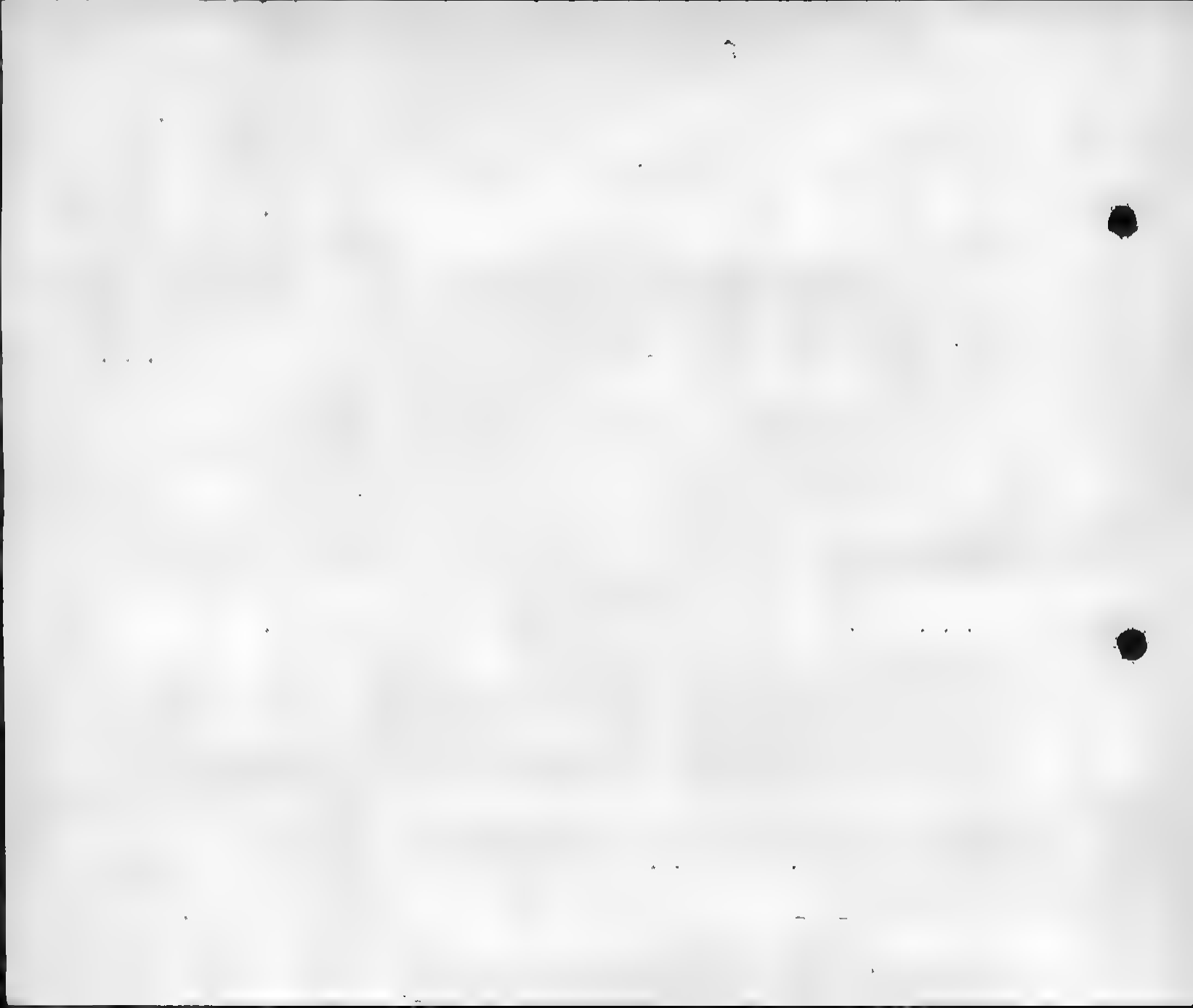
VS. AT5ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9014 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08987

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 mo. 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14	
3. NAME OF DECEASED (Type or print) First Middle Last Estelle Mae Hopkins Spicer		4. DATE OF DEATH Month Day Year August 12, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 January 15, 1884
9. AGE (In years last birthday) 76 7/4 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Hopkins		14. MOTHER'S MAIDEN NAME Mary -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		DATE SIGNED 8/12/60	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8-15-60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR DATE AUG 15 '60	
ADDRESS 5305 Harford Rd		24b. REGISTRAR'S SIGNATURE Arthur J. Ruck	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9016

CERTIFICATE OF DEATH

08989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural New London, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural New London, MD #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Chapel Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH THOMAS</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 1, 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Israel Adams</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-3-6435</u>		17. INFORMANT <u>Mrs. Ruth M. Hatcher</u>		Address <u>Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> DUE TO (c) <u>CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JULY, 1959</u> to <u>AUG. 30, 1960</u> , that I last saw the deceased alive on <u>AUG 30, 1960</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>19 RIDGE RD WESTMINSTER, MD</u> DATE SIGNED <u>AUG 30, 1960</u>							
ACTUAL SIGNATURE <u>William I. Stewart, M.D.</u>				PHYSICIAN'S NAME (Type) <u>WESTMINSTER, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 3, 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Chapel Cemetery, New London, MD #1</u>		22d. LOCATION (City, town, or county) (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Ziegler, Jr.</u>				ADDRESS <u>11111 Western Chapel Rd</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>William I. Stewart</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b 1 yr. 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		d. STREET ADDRESS 54 Chase Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 19 Ridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM R. VEIGA		4. DATE OF DEATH Month August Day 15 Year 1960		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Dec 3, 1957		9. AGE (In years (last birthday) yrs. Months Days Hours M.n. 2		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore Md. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph V. Veiga, Jr.		14. MOTHER'S MAIDEN NAME Jane Gillespie		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. J. V. Veiga, Jr. Westminster Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute, interstitial pneumonitis, bilateral 49.2x DUE TO Conditions, if any, which gave rise to immediate cause (b) 49.2x (a), stating the underlying cause last. DUE TO (c) 49.2x		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County)		20g. (State)		20h. (Country)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DATE SIGNED 8/15/60		Address (Street, city, town, or county) Chicopee, Mass.		REC'D BY REG. STR. 24b. REGISTRAR'S SIGNATURE Charles S. Kraus	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF AUG. 18, 1960		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or country) (State) Chicopee, Mass.	
23. FUNERAL DIRECTOR J. E. Myers Jr., Westminster, Md.		ADDRESS Westminster, Md.		DATE AUG 18 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION



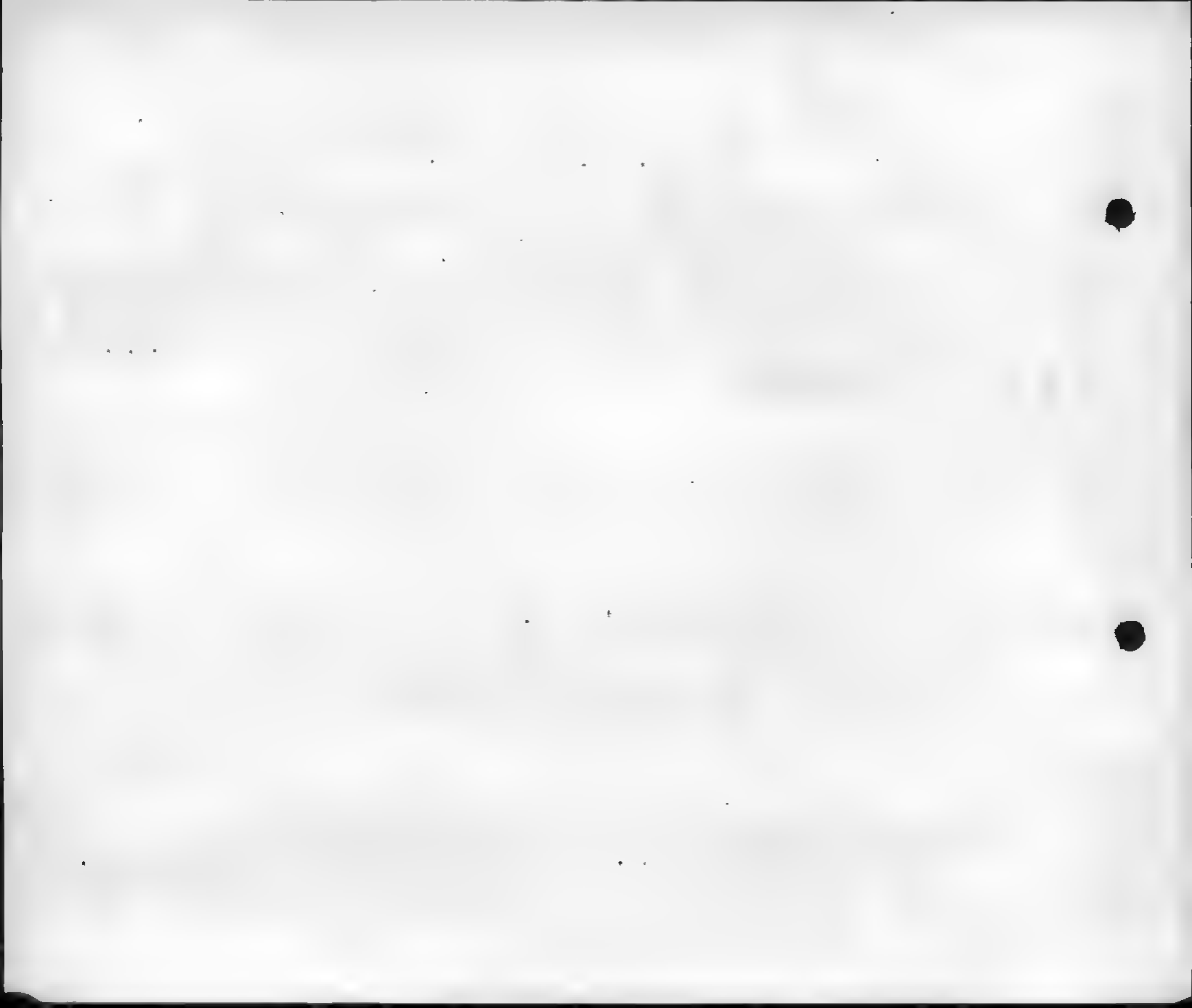
may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9017

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

68391

1. PLACE OF DEATH a. COUNTY Carroll				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4yrs. 3mos. 22days Baltimore 24			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 505 S. East Ave.			
3. NAME OF DECEASED (Type or print) First June Middle Esther Last (Wisniewski) Wallace				4. DATE OF DEATH Month August Day 23 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 25, 1899	9. AGE (In years lost birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 61 Days 23 Hours 22 Min 17	11. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None House wife		10b. KIND OF BUSINESS OR INDUSTRY 217-20-2346		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Wisniewski				14. MOTHER'S MAIDEN NAME Ida - Staniewski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO -		17. INFORMANT Mr. R. Wallace 1923 Address Quemine Rd 22 Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pyelonephritis DUE TO (c) Bronchopneumonia							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 31, 1955 to August 23, 1960 that (I) (we) last saw the deceased alive on August 23, 1960 , and that death occurred at 8:10 PM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo				22b. DATE 8/24/60			
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/27/60		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City town or county) (State) Balto. City Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski 2007 Eastern Ave.				25a. REC'D BY REGISTRAR ALG 20 W		25b. REGISTRAR'S SIGNATURE William S. Fialkowski	



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been

page 3 should be detached for use as the burial

the State Board of Health prior to burial

attending physician and

relayed to the funeral director,

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9019

68993

1 PLACE OF DEATH a. COUNTY Carroll M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton c. LENGTH OF STAY IN 1b 180 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY St. Mary's ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colton's Point d. STREET ADDRESS 12X-2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Alias Walter Jefferson Middle Walter Thomas Young		4. DATE OF DEATH Month August Day 20 Year 1960	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-1-1874
9 AGE (In years last b rthday) 86 yrs. IF UNDER 1 YEAR Months Days Hours Min		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker 10b KIND OF BUSINESS OR INDUSTRY St. Mary's Co., Md. 12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Young		14. MOTHER'S MAIDEN NAME Henrietta Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. 17. INFORMANT Walter Thomas Young - Patient Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiovascular insufficiency Part II Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO Moderately advanced pulmonary Tbc. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Feb. 22, 1960 to Aug. 20, 1960, that (I) (we) last saw the deceased alive on Aug. 20, 1960, and that death occurred at 3:10 PM, from the causes and on the date stated above			
22a SIGNATURE Edgars M. Maculans M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt.		22d. ADDRESS Henryton State Hospital, Henryton, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 8/23/60	23c NAME OF CEMETERY OR CREMATORY All Saints	23d LOCATION (City, town, or county) (State) Oakley, Md.
24. FUNERAL DIRECTOR'S SIGNATURE W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR DATE AUG 23 '60	
25b. REGISTRAR'S SIGNATURE LEONARD TOWN, MARYLAND			

This certificate is to be signed by the attending physician, the medical examiner, or the coroner, and in any event within 72 hours after death. It should be filed in the death record. Pages 1 and 2 should be filed in the death record.



1
 TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9020

CERTIFICATE OF DEATH

Reg. Dist. No. 08394

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Westminster, Md.				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Westminster, Md.			
f. STREET ADDRESS Old Washington Road R.D. # 6 Westminster, Md.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Gloyd Last Zendgraft				4. DATE OF DEATH Month Aug. Day 13 Year 19 60			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1906		9. AGE (In years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) boiler-fireman				10b. KIND OF BUSINESS OR INDUSTRY laundry		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Albert G. Zendgraft			
14. MOTHER'S MAIDEN NAME Mary E. Buckingham				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -----			
16. SOCIAL SECURITY NO. 218-03-6900				INFORMANT Address sister- Mrs. Joseph H. Martin R.D. #6 Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Original site - colon DUE TO (c) -----							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/30/58 to 8/13/60 19 60 , that I last saw the deceased alive on 8/13/60 , 19 60 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M.E. Robertson		M.D. New Windsor, Md.		ADDRESS (Street, city or town, state) 8/13/60		DATE SIGNED 8/13/60	
PHYSICIAN'S NAME (Type) -----		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 8/16/60		22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Westminster Md.		23. FUNERAL DIRECTOR'S SIGNATURE James G. Saffell	
23. FUNERAL DIRECTOR'S ADDRESS Westminster Md.		24a. REC'D BY REGISTRAR DATE AUG 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9021 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20yrs. 4mos. 14days Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Pearl Middle Ziegler Last Ziegler				4. DATE OF DEATH Month August Day 4 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23, 1899	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical work				10b. KIND OF BUSINESS OR INDUSTRY Unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Andrew Ziegler				14. MOTHER'S MAIDEN NAME Margaret Yakel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V. disease DUE TO (c) years							INTERVAL BETWEEN ONSET AND DEATH Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type. Free on lip							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell to the floor on the ward.					
20c. TIME OF INJURY Month, Day, Year 7:00 PM 7/17/ 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Marsh, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-8-60		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Height Sykesville, Md.				24a. REC'D BY REGISTRAR DATE AUG 10 '60		24b. REGISTRAR'S SIGNATURE Arthur A. Height	

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NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF MEDICAL EXAMINER: [illegible]
DATE: [illegible]